F 000 INITIAL	ER OF ELIZABETHT SUMMARY STATEMENT ( M DEFICIENCY MUST RE ILATORY OR LSC IDENTI	OF DEFICIENCIES	ID PREFIX	1641	ET ADDRESS, CITY, STATE, 714 CODE HIGHWAY 19E ABETHTON, TN 37643	11/	<u>(01/2017</u>
(X4) ID (EAC TAG REGINT TAG REGIN	ER OF ELIZABETHT SUMMARY STATEMENT ( M DEFICIENCY MUST RE ILATORY OR LSC IDENTI	OF DEFICIENCIES	ID PREFIX	1641	HIGHWAY 19E ABETHTON, TN 37643	1 11/	01/2017
F 000 INITIAL	SUMMARY STATEMENT ( M DEFICIENCY MUST RE ILATORY OR LSC IDENTI	OF DEFICIENCIES	ID PREFIX	1641	HIGHWAY 19E ABETHTON, TN 37643		
F 000 INITIAL	SUMMARY STATEMENT ( M DEFICIENCY MUST RE ILATORY OR LSC IDENTI	OF DEFICIENCIES	ID PREFIX		ABETHTON, TN 37643		
F 000 INITIAL	M DEFICIENCY MUST RE ILATORY OR LSC IDENTI	PRECEDED BY FULL	PREFIX	T			
An ann	COMMENTS		YAG		PROVIDER'S PLAN OF CORRECTION (EACH) CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (CONTINUE)	O fue:	(X5) COMPLE DATE
#42774 Life Car were cit CFR 48:	ual Recertification s ation of complaints a was conducted on " b Center of Elizabet ad related to compla 3, Requirements for	#40222, #40437, and 10/30/17 - 11/1/17 at thton, Deficiencles aint #40222 under 42	F 000		Life Care Center of Elizabethton is committed to upholding the highest standard of care for our residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation		
SS-D FOR HIC		DE CARE/SERVICES IG	F 309	]   	with the State of Tennessee Department of Health toward the best interest of those that require the services that we provide.		
Quality of applies to residents facility me services practicate well-bein	f life is a fundamen	tes provided to facility ust receive and the essary care and the highest and psychosocial te resident's			While this plan of correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted on October 30-November 1, 2017. This plan of correction is the facility's allegation of substantial		,
Quality of applies to facility reassessmuthat resides accordance.	uality of care if care is a fundament of a resident, the ents receive treatment and care if the ents receive treatmer with professional the comprehensive	are provided to ne comprehensive e facility must ensure ent and care in I standards of	F309		compliance with federal and state requirements.  .  What corrective action(s) will be acc	romplishe	ah.
care plan but not itr	, and the residents' nited to the following fanagement.	choices, including	;		for those residents found to have be by the deficient practice: Resident #138 was discharged prior	en affect	ted
The facili provided consisten the comp and the year.	y must ensure that to residents who red t with professional s rehensive person-cr esidents' goals and p	preferences,		-	Center of Elizabethton's annual surv	· 1	2/15/20
MA I A	OR PROVIDER/SUPPLIE	R REPRESENTATIVE'S SIGNA	ATURF	W.	ministrator	(X	O) DATE

FORM CRIS 2567(02-99) Previous Versions Obsolute

program participation.

Event ID: VBW711

Facility by: 1N1804

Il continuation sheet Page 1 of 4

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			DOWNER			
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	): 11/14/2017 AAPPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF COURECTION		(X1) PROVIDENSUPPLIERICLIA IDUNTIFICATION NUMBER:	(X2) MULTI	TIPLE CONSTRUCTION	OMB_NC	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
445302		B. WING			44/04/0047			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	<u></u>	01/2017		
LIFE CA	RE CENTER OF ELIZA	ABETHTON		1641 HIGHWAY 18E ELIZABETHTON, TN 37643	_			
(X4) ID PREFIX TAG	SUMMARY STATUMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRE	OUR IS OR	COMPLETION COMPLETION		
	(I) Dialysis. The fact residents who requires services, consistent of practice, the comparation, and the repreferences. This REQUIREMEN by: Based on facility poreview, and interview physician's order for process a physician's resident (Resident #reviewed.  The findings included Review of the facility Medication' not dated are administered safe each medication in the Imedication is given medication is not administration in the record reason on MA not presentcheck the wrong drawercasupervisor to obtain the Review of the facility leostomy, or Urostom revealed, " procedures facts and are method naintenance of a paticulation regardinare documentation	lifty must ensure that re dialysis receive such with professional standards prehensive person-centered esidents' goals and  T is not met as evidenced licy review, medical record v, the facility failed to follow a colostomy care and failed to s order for an antibiotic for 1 138) of 25 residents  d: policy, "Administration of d revealed, "medications elyappropriatelyInitial ne correct box on the MAR ration record] after the circle initials on MAR if ninistered as ordered and R medication is ordered but drawersif it was placed in all the pharmacy or the medication"  policy "Colostomy, ty", revised 11/28/16 e developed to provide a if for the care and	F 309	2. How you will identify other restricted by deficient practice and what convill be taken:  a. All residents who have an care was audited by DON of 2017.  b. No other residents who recare were affected by the appractice.  3. What measures will be put into systematic changes you will mathe deficient practice does not a. The staff development cooleducate 100% of licensed in November 30, 2017 on Life of Elizabethton's Medication Policy.  b. The Oirector of Nursing will of residents with ostomy's the is complying with Medication Policy weekly for 3 months compliance achieved.	the same rective action order for oster on November quired ostom alleged deficit place or whicke to ensure does not rectionator will urses by Care Center on Administra audit the MA o ensure nur Administra	omy 1,  y ent that ur: tion AR sing		

@007/011

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				DOMEC		
<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	): 11/14/20 1 APPROVE	17 =D
STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERICLIA			<del></del> -			OMB NO	0938-03	91
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY		
			A BUILD	ING _	cor	COMPLETED		
		D. WING			Ì			
NAME OF PROVIDER OR SUPPLIER		7				11/01/2017		
LICE CARE CENTER AS ALLE			40	REET ADDRESS, CITY, STATE, ZIP CODE 41 HIGHWAY 18E		T	コ	
LIFE CARE CENTER OF ELIZABETHTON			ì		LIZABETHTON, TN 37843			- 1
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		<del></del>	<del>-</del>				١
PREFIX J (EACH DEFICIENCY		MUST BE PRECEDED by FILL	ID PREFIX	.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	ON	(Xa)	П
1'AG	REGODATORY CIR LS	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRIC	PRIATE	DATE	۱ ۱
	<del></del>		<del></del>		DEFICIENCY)		†	- [
F 309	T T T T T T T T T T T T T T T T T T T		F 308	- 1	<ol> <li>How the corrective action(s) will</li> </ol>	be monito	red	ᅥ
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				180	to ensure the deficient practice v	vill not rec	ur.	- 1
	person-centered car	replan"		- 1	i.e. what quality assurance program will be p		out	ſ
	Review of the facility	/ policy "Physicians		1	in place:			
	Orders/Transcription	" revised 10/2004 revealed			<ol> <li>The DON will present the res</li> </ol>	ults of the	<u>,</u>	-
	"proper channels of	of communication are used to			audits to the Performance In	proveme	nt	1
	i ensure accurate del	IVERV Of medications and	1	- 1	Committee monthly.  b. If it is deemed necessary by the commit			1
	treatmentsreceivin	III an orderphysician must					ttee.	1
	Write order on order sheeteach timenurse		]		additional education may be	provided.	the	[
	chartsphysician on	ders section should be	)		process evaluated/revised, a	nd/or the		1
	checked for new orderssignorder sheetindicating orders have been				audits reviewed for 3 months	or until		1
	transcribeddraw line on order sheet below the ordersend copy to pharmacy"		İ		100% compliance is achieved			
			1		<ul> <li>c. The Performance Improvement</li> </ul>	nt Commi	ttee	
				1	consists of the Executive Dire	ctor, the		1
Resident #138 was ad		dmitted to the facility on			Director of Nursing, the Medical Director,  And the Health Information Management			
	3/15/16 with diagnoses of Chronic Obstructive		•					
	Pulmonary Disease,	Heart Failure, Anxiety			Director, Director of Mainten:	ance.		
}	Dementia Without Re	on, Muscle Weakness, ahavioral Disturbance.		ľ	Director of Environmental Ser	vices, the		
1	Depression, Adult Fa	illure To Thrive and		1	Activities Director, the Social :	ervices		1
ł	Depression, Adult Fallure To Thrive, and Gastroesophageal Reflux Disease.				Director, the Admissions Director	tor, and		Ł
J	, 3	100000		ı	the Pharmacy Consultant.		la c lone o	1
	Medical record review	v of the Quarterly Minimum		Ι.	_		/15/2017	ŀ
	Data Set (MDS) date	d 9/5/16 revealed Resident	F309		<ol> <li>What corrective action(s) will be:</li> </ol>	ecomplist	ned '	]
].	#138 had a Brief Intel	rview of Mental Status		1	for those residents found to have	been affe	cted	]
	(Dilvio) score of 12, if	ndicating Resident #138 had pairment. Continued		1	by the deficient practice:			l
	moderate cognitive in Maview revealed Resid	dent #138 regulred limited			Resident #138 was discharged pri	or to Life (	Care	ľ
	assistance of one per	son physical assist for		1 ,	Center of Elizabethton's annual su	rvey.		
i :	personal hygiene. Fui	ther review revealed		4	. How you will Identify other reside	nts having		
Į!	Resident #138 used a	in ostomy for bowel		1	the potential to be affected by th	e same		
[1	continence.	1			deficient practice and what correct	tive action	`	ĺ
1.	Modiant access	. <b>.</b>			will be taken:			[
	viedical record review	of the Physician Orders			a. All resident's charts will be au	dited by	j	
	and bag weeklystart	ed "change ostomy wafer			November 20, 2017 by Directi	of Nursi	ng i	
	wa nad Meckilima(BL	ngie a/a/ 10"".			to ensure all physician orders	were note	d	
<u> </u>	Medical record review	of the Progress Notes			and transcribed accordingly.			
ĺ	lated 11/11/16 reveals	ed "Residents			b. No other residents were affect	ed by the	ľ	
M CMC PREVIOUS (IN 1971)		<del></del> -	<u> </u>	alleged deficient practice.				

2008/011

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/14/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES QMB NQ, 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (Kii) DATE SURVEY A. DUILDING COMPLETED 445302 B. WING NAME OF PROVIDER OR SUPPLIER 11/01/2017 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF ELIZABETHTON 1641 HIGHWAY 18E ELIZABETHTON, TN 37643 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X3) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REPURENCED TO THE APPROPRIATE TAG DATE DEFICIENCY What measures will be put into place or what 3. F 309 Continued From page 3 F 309 systematic changes you will make to ensure daughter...In facility on 11/10/16...noted...ostomy that the deficient practice does not recur: bag/wafer...not been changed as ordered..." a. The staff development coordinator will Medical record review of the MAR dated 11/2016 educate 100% of licensed nurses by revealed colostomy care was not completed on November 30, 2017 on Life Care Center 11/2/16. of Elizabethton's Physician's Orders/ Transcription policy. Medical record review of the Physician/Prescriber b. The Director of Nursing and/or the Telephone orders dated 11/23/16 revealed Staff Development Coordinator will audit ...Rocephin [antibiotic] 1gm [gram] IV [Intravenous] Q [every] day x [times] 10 days..." charts twice weekly to ensure nightly chart checks are completed and physician orders Medical record review of the MAR dated 11/2016 are noted/transcribed for 3 months or until revealed the physician's order for Rocophin to 100% compliance is achieved. start on 11/23/16 was not started until 11/24/16. 4. How the corrective action(s) will be monitored Interview with the Director of Nursing (DON) on to ensure the deficient practice will not recur, 10/31/17 at 3:26 PM, in the DON's office, i.e. what quality assurance program will be put confirmed the colostomy care was not done on in place: 11/2/17, and the Rocephin was not administered The DON will present the results of the until 11/24/17. audits to the Performance Improvement Committee monthly, b. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved. The Performance Improvement Committee consists of the Executive Director, the Director of Nursing, the Medical Director, And the Health Information Management Director, Director of Maintenance, Director of Environmental Services, the Activities Director, the Social Services Director, the Admissions Director, and the Pharmacy Consultant.